

**Effective Date Phase I: 1/5/98**

**Effective Date Phase II: 8/12/98**

**Effective Date Amendment (Elimination of 3-month waiting period): 7/1/02**

**Effective Date Amendment #3 (unborn children): 1/1/03**

**Effective Date Amendment #4 (eligibility to 200%): 7/1/03**

**Implementation Date Phase I: 1/1/98**

**Implementation Date Phase II: 10/1/98**

**Implementation Date Amendment (Elimination of 3-month waiting period): 7/1/02**

**Implementation Date Amendment #3 (unborn children): 1/1/03**

**Implementation Date Amendment #4 (eligibility to 200%): 7/1/03**

**Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

**Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))**

**Illinois has chosen to target children who are under the age of 19 and who are from families with incomes at or below 133 percent of the federal poverty level (FPL). Health benefits coverage will be provided to these children through a Medicaid expansion that will cover children who are between ages 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The expansion will serve an additional 40,400 children. Illinois will implement this expansion on January 5, 1998.**

**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1.  Geographic area served by the Plan: **The plan will be statewide.**

4.1.2.  Age: **Under 19 years of age.**

4.1.3.  Income: **The child's family income is above 133% and at or below 200% of the federal poverty level. Family income considers all persons living in the household, including those that are not applying for benefits. Certain income that is exempt under Title XIX is exempt under Title XXI. This includes the exemption of certain employment-related costs, child care costs, and earned income of children who are not minor parents.**

4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): **No asset limitation is applied. Met spend down cases are not eligible for KidCare Share or KidCare Premium.**

4.1.5.  Residency (so long as residency requirement is not based on length of time in state): **The child must be a resident of the State of Illinois and a U.S. citizen or qualified legal immigrant. Qualified legal immigrants are non-citizens who meet one of the following categories:**

- 1) **Unmarried dependent children of a United States Veteran honorably discharged or a person on active military duty,**
- 2) **Refugees under Section 207 of the Immigration and Nationality Act,**
- 3) **Asylees under Section 208 of the Immigration and Nationality Act,**
- 4) **Persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act,**
- 5) **Persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980,**
- 6) **Persons lawfully admitted for permanent residence under**

**Section 8. Cost Sharing and Payment** (Section 2103(e))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1.  YES

8.1.2.  NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: **A family with a family income above 133% and at or below 150% of the FPL (KidCare Share) has no premium requirements, as required by federal law. A family with an income above 150% through 200% of the FPL (KidCare Premium) is charged a premium of \$15 per month for one child, \$25 per month for two children, and \$30 per month for three or more children.**

8.2.2. Deductibles: **None.**

8.2.3. Coinsurance or copayments: **None.**

8.2.4. Other: **Copayment requirements under KidCare comply with federal regulations. A family with a family income above 133% and below 150% of the FPL (KidCare Share) has a \$2 copayment for medical visits and prescriptions, including use of the emergency room. A family with an income above 150% through 200% of the FPL (KidCare Premium) has a \$5 copayment for medical visits, a \$3 copayment for generic and \$5 copayment for name brand prescriptions, and a \$25 copayment for nonemergency use of the emergency room. All families have a \$100 annual cap on copayments. No copayments are charged for well-baby, well-child, or immunization services in any plan. In addition, no copayments are charged for visits to health care professionals or hospitals solely for lab or radiology services or routine preventive and diagnostic dental services. American Indian/Alaska Native children are not required to make copayments or pay premiums.**

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))